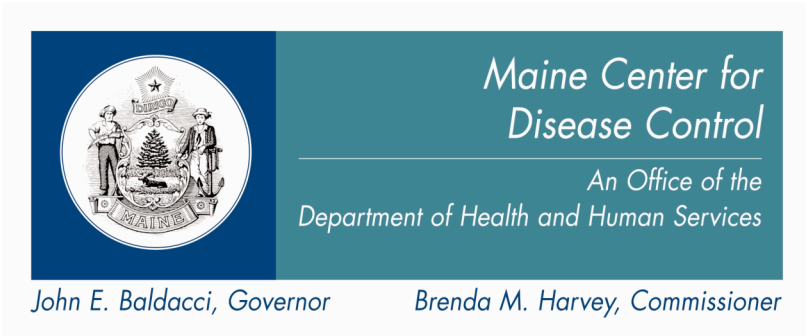
Disconnected Youth: A Needs Assessment
August 2007

Conducted as part of Maine Program Enhancement and Integration of Maine Youth Suicide Prevention Project # SM57396 of the Substance Abuse and Mental Health Services Administration (SAMHSA)

Prepared for
The SAMHSA Youth Suicide Prevention Project
Maine Youth Suicide Prevention Program
Maine Center for Disease Control and Prevention
Department of Health and Human Services



By Cheryl Saliwanchik-Brown, M.A.
Doctoral Candidate
Research Assistant

Center for Research and Evaluation
College of Education and Human Development
University of Maine

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Maine Youth Suicide Prevention

Education, Resources and Support–It's Up to All of Us.

A program of the Governor's Children's Cabinet including the Departments of Health and Human Services, Education, Corrections, Labor and Public Safety

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Introduction

"You want to know what's behind suicide? The homelessness is behind suicide. Because people get to that point where they feel like they're at rock bottom and they can't do anything else. No matter how hard you try to climb out of that pit, you're stuck in it. It's just easier to blow your head off, or hang yourself, or swallow a bottle of pills. It's a long term answer to a short question."

(Female, 19, who became homeless at 16-years-old)

Suicide is among the top three leading causes of death for 18-24 year olds in Maine (for males, it is the second leading cause of death; for females it is the third leading cause of death.)[1] In Maine, approximately 14,000[2] youth in this age-group are also considered "disconnected."[3] Many of these homeless and jobless young adults live with several identified suicidal risk factors on a daily basis. A recent study by Tondo, Albert and Baldessarini (2006)[4] found lack of access to health care could also contribute to suicide risk. One objective of the Maine Youth Suicide Prevention Project (MYSPP) was to assess the health care needs of disconnected youth in the project areas of Knox, Piscataquis and Sagadahoc counties and, further, to use the information to help inform programs or resources to alleviate some of this risk.

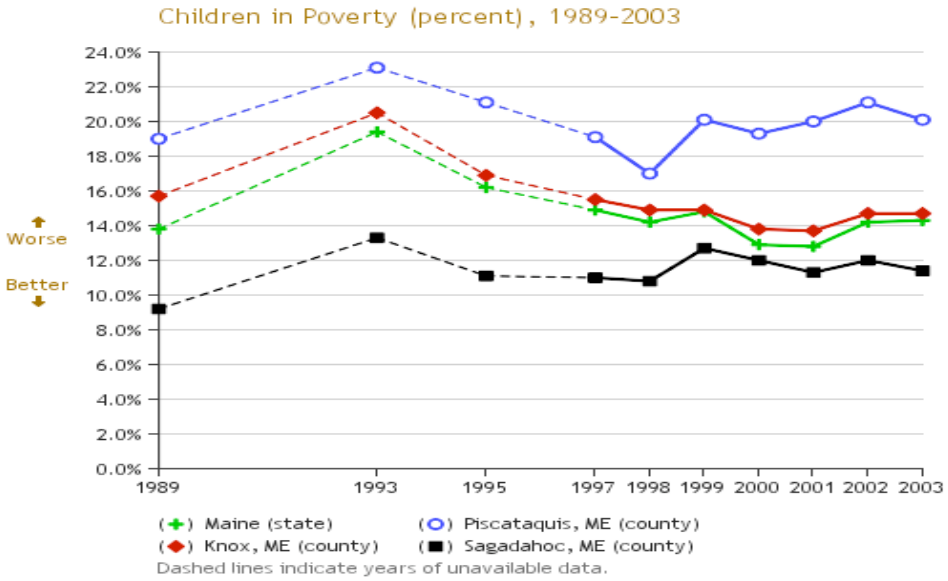
This report explores not only how disconnected youth access health care, and especially in the event of suicidal ideation, but the challenges and barriers youth face in maintaining a healthy standard of living as a population at high risk for death by suicide. This report includes the voices of several youth who access area shelters for food and housing, as well as illustrates some of the challenges and barriers Maine mental health agency providers, substance abuse counselors, and other community agencies and adults that work with this population, encounter. Both youth and service providers agree that the necessity for continued support and treatment services for young adults who are homeless, or who are transitioning from group homes to independent living is crucial to overcoming conditions or feelings that contribute to suicide risk.

Demographics of Youth from Project Areas

In Knox, Sagadahoc and Piscataquis counties, homelessness and joblessness for young adults may have been precipitated by growing up in communities with high rates of children living in poverty, high rates of pre-teen and teen pregnancy, and high unemployment rates (it is important to note that this is a speculation and has not been confirmed through research).

In all project regions, over ten percent of children from birth to age seventeen live in financial poverty; the highest percentage of children being from Piscataquis county with an average of 20% of all children from this county growing up impoverished (See Figure 1). Sadadohoc county, in southern Maine, has the lowest percentage of children living in poverty with a consistent rate of approximately 12% over a range of six years. Knox county shows that 14 to 15% of its children live at or below the poverty rate.

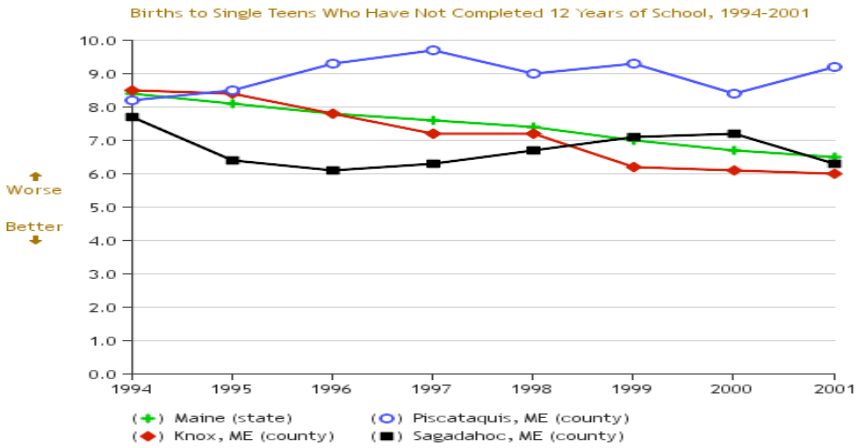
Figure 1. Children Living in Poverty in Project Regions[5]



SOURCE: Annie Casey Foundation, www.aecf.org, Access date: 4/19/07.

Births to girls who had not yet completed twelve years of school in the project regions are also high in the Piscataquis County project area. In 2001, at the midpoint of a five-year period from 1999-2003, 9.2 females out of 1,000 gave birth as single moms. Sagadahoc and Knox counties, respectively, were lower, with approximately 6 out of 1,000 single females without high school diplomas having children (See Figure 2 below) before high school graduation.

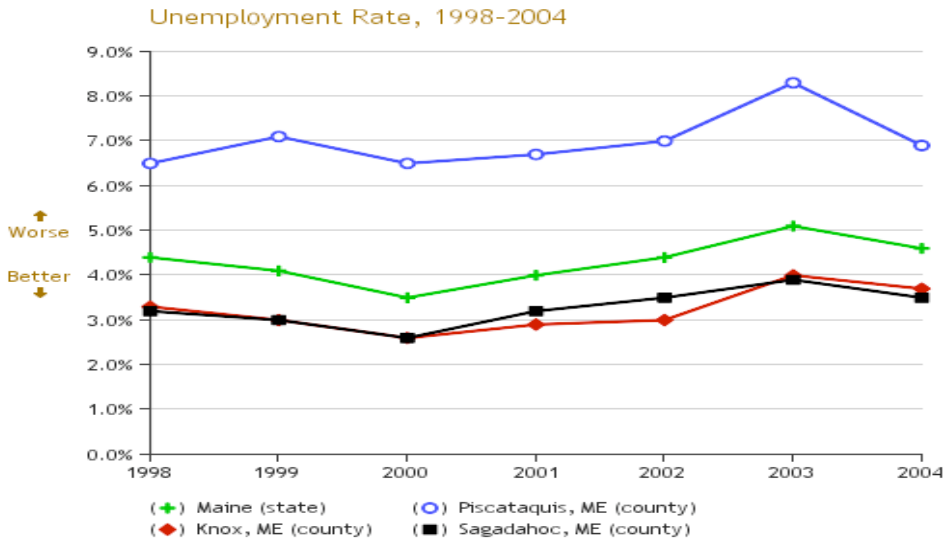
Figure 2. Births to Teens in Project Regions



SOURCE: Annie Casey Foundation, www.aecf.org, Access date: 4/19/07.
DEFINITION: Rates per 1,000 females aged 10-19. Year shown is the annual average of a 5-year period, so 1998-2002 is represented as 2000 data.

Unemployment rates in two project regions (see Figure 3 below), Knox and Sagadahoc counties, are lower than in Piscataquis county and the state unemployment rate. While Piscataquis shows a slight decline in 2004, it is still above the state average at 6.9% with the state average being 4.6%, and Knox and Sagadahoc fairly similar at 3.7% and 3.5%, respectively.

Figure 3. Unemployment Rate in Project Regions



SOURCE: Annie Casey Foundation, www.aecf.org, Access date: 4/19/07
DEFINITION: Unemployed persons aged 16 and over, annual average. Percent is the average number of unemployed people divided by the average number of employed people in the civilian labor force.

This high rate of unemployment and children living in poverty in the project areas also affects other child welfare subsidies, such as Temporary Aid to Needy Children (TANF) and school lunch programs. In 2005, more than 9% of children born to 17 year olds in Piscataquis county were enrolled in the TANF program, and 53.3% of children from Piscataquis county received free and reduced school lunches.[6]

Drug use and abuse is also a suicidal risk factor. This population is the fastest rising population for opiate addiction in Maine (Maine Office of Substance Abuse, 2006). The most significant increase in drug abuse treatment is with 18-24 year old females being treated for opiate abuse. In 2006, as many as 570 cases of opiate addiction treatment were reported, whereas six years earlier, in 2000, 108 cases were reported in Maine. This amounts to a staggering 427% increase in six years.

Youth aging out of foster care or homeless youth may have suffered childhood physical or sexual abuse, neglect or abandonment, familial drug and alcohol abuse. These youth have more incidents of unplanned pregnancy, less education, less job training, and less financial management skills (Courtney and Heuring, 2005). Without supports in place, transitioning to adulthood for homeless and jobless young adults often seems hopeless and according to Maine youth, suicidal ideation is common.

Methods

Using informal telephone interviews and focus groups, information was gathered regarding the accessibility and quality of health care from the perspective of the youth, as well as the perceptions of a selection of health care providers and community providers who work with the disconnected population in the project regions. The following describes the methods used to obtain these perspectives.

Youth

Two agencies in Bangor and Portland which serve youth who reside, or have resided, in the target areas offered to recruit individuals for a focus group and set up a time and a place for the focus group to meet. They indicated that they knew youth who visited their sites, or they knew how to contact youth who might be interested in participating. Chris Betts, Outreach Program Manager, and Katie Camplin, Teen Center Case Manager, were also provided with a flyer they could post in a conspicuous area in which the youth who accessed the facility would be made aware of the upcoming focus group. A letter to the contacts ensured that care was taken to make sure youth volunteered for the project and did not feel obligated to participate in any way. The site administrators arranged the focus groups at a time and on a day that typically brought participants to the site, such as a group meeting or a dinner. Those youth who volunteered to participate received a $10 gift certificate to a local fast food restaurant at the end of the group. Using semi-structured protocols (see Appendix A), the facilitator conducted an audio-taped interview at the outreach sites. The tapes were not transcribed but were, rather, used to supplement notes taken by the facilitator.

Service Providers

Informal telephone conversations with Maine state administrators, project coordinators and other community service providers were conducted to determine their understanding of the needs and challenges of youth from 18-24 years old who are considered "disconnected." Discussions with service providers and agency personnel were informal and took place on several different levels and occasions as more information was gathered. In addition, the Department of Health and Human Services was contacted for comments regarding Maine's youth who are aging out of foster care.

Using the SAMHSA Youth Suicide Prevention Project contact sheet, project coordinators were contacted either by phone or by email (often both). They, in turn, provided additional contact information for other community service agencies or adults in their areas who worked exclusively with adolescents or disconnected adolescents. Among these contacts were service providers at adult homeless shelters, adolescent group homes, food banks, clinics, churches, and substance abuse and mental health providers.

The Focus Groups

"I have a disability. I can't go to the doctors - I'm not sure what the difference is between insurances, there's nobody to tell me. You could get a case worker anywhere… but you have to have scheduled appointments every week – which I can't make…– so, you know, there's nobody to help with that sort of stuff – like setting up appointments, what kind of appointments do you need, how you can get dental help."

(Female, 21, aged out of state custody)

Three focus groups of 18 young adults, whose ages ranged from 18-23, met at two outreach programs and at different times in Portland and Bangor. The contacts at these outreach programs provided a room and a safe place to meet. The Portland group provided a conference room, the two Bangor groups met in the shelter kitchen and sat around a kitchen table. Males and females were equally represented. (Note: This was not planned; the groups were chosen only by those who volunteered to be interviewed.) Within the population who volunteered for the focus groups, nine were males and nine were females, one male was African-American, two of the women were mothering children (one, 18, brought her 17 month-old to the focus group and one, 21, indicated in the course of the discussion that she was the mother of two children and that she was in jeopardy of losing them to DHHS custody), one, 18, indicated that she gave up a daughter to adoption when she was 15-years-old. Those from Maine were from Penobscot, Washington, Waldo and Piscataquis counties, with several in the Portland group indicating that originally they were from out-of-state, specifically Louisiana, Arizona and New York.

The participants seemed comfortable stating what they believe, yet often responded with a bravado that may have masked what they felt, perhaps to preserve their own sense of self-worth or a sense of pride.[7] One Bangor group became very animated when someone mentioned a recent article in a local newspaper that, when published, labeled them "throw-away kids." They were upset that not only had they volunteered to tell their stories to the reporter and allowed the paper to photograph them, one with her child, but that they thought they were going to be represented differently. While the reporter may have been using the term to elicit an empathic or sympathetic response from her audience, for the youth, the term was degrading and humiliating. States one female, "We allowed them to come in to our only *sane* place to be – and they do that?! I feel definitely violated." One says, "We may be throw away kids, but we don't need it rubbed in our faces…If that isn't adding acid to a cut." Says another, "They told us it was going to be a story to better (name of town) the lives of the homeless kids, and then they call us "throw-away kids"? Nobody's going to walk in here [now] and say 'look I'm homeless and I need help'."

When I asked the groups how they knew to go to the program where we were interviewing, their answers ranged from being "recruited" – the Bangor program has a service that sends outreach workers into the community and looks specifically for youth who are "hanging out" in the downtown district – to being residents as teens in the facility and knowing about the program from that experience. Some knew about the outreach programs from friends and family – two mentioned older siblings. Many from the Bangor program have been regular attendees of Streetlight meetings for as much as four years. One indicated that

she knew about the program because she was looking for clothing, and one stated that he needed something to eat. Friends who visited the centers referred several of the participants.

Accessing Physical Health Care

Each group was asked how they access regular health care and mental health care, including transportation and payment of health care. They were also asked what they would do in the event of a friend disclosing suicidal thoughts or what they would do in the event that they experienced suicide ideation and finally, what they would recommend as services or support for their situations.

When asked what they would do if they needed to see a doctor, their responses were:

- Go to the Emergency Room of the local hospital. One participant in Bangor said, "It depends on if it's a weekday or a weekend. If it's a weekend, you go to the ER. If it's a weekday you go to your doctor" (female, 20).
- Make an appointment with doctors and primary care providers, which they described was due to having MaineCare health insurance.
- One was still seeing a family practitioner.
- "Walk-in" care.

Many from the focus groups said they would *not* seek physical health care because of personal preference and not because of systemic barriers. For some, the extent or immediacy of the health care depended on "how bad it hurts." Two participants responded they wouldn't go to a hospital unless it was dire. Most indicated they would go if they really *had* to. One female stated, "I don't go to the hospital or doctors unless, I'm like, dying. I don't like doctors."

Transportation. Transportation to appointments for the Bangor youth was much easier than for the Portland group. The Bangor groups listed bus services like Bangor Area Transportation (B.A.T.), Project Ride, and the Manna bus. They explained that for most of the rides they need to only show their MaineCare card (MaineCare will pay for a 3-appointment per month bus pass), or that DHHS needs to set up the ride 24 hours ahead of time. Some mentioned that they walk to services, and some said they call Streetlight and the staff there will take them to medical appointments.

Paying for appointments. The youth responded that they almost always paid for health care through MaineCare, with the exception of one male, 21, who wasn't clear about how to get MaineCare and one Portland participant who claimed that he made too much money and didn't qualify for MaineCare services. None of the participants had any other kind of insurance. Most agreed there were benefits and limitations with MaineCare. One male says of the benefits, "You know for free insurance, you know, it pays for my prescription, it gets me in to see a doctor."

Barriers and Challenges to Accessing Physical Health Care for Youth

Aging out. One youth believed that there is a lack of health care help when you are not in the "system." At 18, she turned down extended services, V9 benefits, offered to youth who age out of foster care and now, at 21, she is finding several challenges to receiving adequate physical and mental health care. She states:

> "I recently got into some trouble with MaineCare [she clarified later that she didn't mail out the paperwork on time] and I got it taken away from me and I have a disability. I can't go to the doctors, I'm not sure what the difference is between insurances, there's nobody to tell me. You could get a case worker anywhere – like CHCS [Community Health and Counseling Services], or any place like that they'll help you find it – but you have to have scheduled appointments every week – which I can't make. I couldn't have a counselor down there – so, you know, there's nobody to help with that sort of stuff – like setting up appointments, what kind of appointments do you need, how can get dental help."

Insurance limitations. Other barriers the youth discussed were limitations with MaineCare insurance. While their insurance benefits are free, they must "look around" for a provider who accepts MaineCare and they must use "cheap" or generic brands of some medications. Providers may limit the amount of MaineCare patients they accept and may deny services to a MaineCare client if they choose. Another challenge to accessing MaineCare happens when a youth turns 21. They explained that more paperwork needs to be filled out in order for the coverage to continue until the youth turn 23. The MaineCare Member Handbook (available on-line from the Maine Department of Health and Human Services) confirms much of what the youth discussed and especially with medications. MaineCare has a "Preferred Drug List" that lists drugs that need prior authorization. MaineCare may deny a drug that a physician has prescribed and, unless a patient requests a hearing, that prescription must be changed or must go through MaineCare's approval process, which could take weeks. Other limitations are times a client can utilize a service and that MaineCare reserves the right to change covered services at any time.

Transportation. While the Bangor group indicated that transportation was not a barrier for accessing health care, the Portland focus group expressed a general dissatisfaction with the availability of transportation. Rockland service providers also believed that transportation to medical appointments, both to physical and mental health providers was a limited resource in the mid-coast region.

Accessing Mental Health Care.

When mental health care was addressed in the focus groups, most of the youth responded that this was a topic with which they had much experience. Most were fairly negative about the experiences they had with counselors and therapists, some agreed that they had good experiences, but not as a whole. Only one out of the 18 participants had *never* seen a mental health counselor.

In the course of the discussion, although not directly addressed, youth mentioned being treated for anger management, drug abuse, and also participated in family counseling.

When asked what they would do currently if they felt like they needed to see a counselor or a therapist they responded:

- "checking yourself into [names a health care facility]."
- "deal[ing] with it on my own."
- currently seeing a counselor on a regular basis – one male, 18, was seeing three mental health care providers on a regular basis.
- would go to friends or family before they would go to a counselor.

This question was followed with, "How would you find a counselor if you needed one?" One young woman, the mother of two toddlers, declared she would, "tweak-out in front of a police officer!" and the police would take her in – she would go to jail first, she declared. I followed-up her comment by asking her if she would still do that now that she was a mom. She replied, "With what I'm going through right now – Hell ya!" One male, 18, said, "I've never felt like I've needed to go, I've always been *forced* to, but if I felt like I needed one I'd probably go." He indicated that the first thing he'd do was come to the outreach program and ask them to refer him to a counselor. Others in the Bangor group agreed either verbally, or by nodding their heads.

Barriers to Seeking Mental Health Care

Negative prior or past experience with counselors or therapists was a running theme through the focus groups when they were asked what would stop them from seeking mental health care. Listed are responses about negative mental health care that these participants believed would stop them from seeking care:

Trust. Many believed that they could not trust counselors or therapists. Some participants felt that they had been "lied to" or "stabbed in the back." This was explained as getting into trouble for disclosing conditions or situations with a counselor that was later repeated back to the caregiver, only to follow with repercussions to the youth. One young woman, 21, spoke about inappropriate counselor behavior and "holding" her down while he "put his hand over my mouth, I'd spit in it and he'd rub it in my face." Another counselor had befriended a youth and, after a 4 year patient-counselor relationship in which the youth had to "learn to trust" him, he moved out-of-state and told her he would stay in contact - but didn't. She then said that she found out he does keep in contact with others – but not with her. She states, "Some counselors take the counselor-patient relationship too far and end up making it worse because people have attachment problems."

Method of counseling. When the youth perceived that counselors "told you how you felt", rather than asking how the youth felt, they were angered and offended. Some stated that counselors used "pat" language and were not genuine in their responses. An example of this was illustrated by one exchange by in the Portland focus group:

1st Male: "I hate it when they say, 'How do you feel about this?' - I just *told* you how I felt!"

2nd Male: (mocking) "Thanks, we're making good progress here."

1st Male: "They just talk to you and shit like that and they don't even have a God-damn clue what's going on. Just because they went to school for a bunch of years they think they know what they're talking about - but they really don't."

A Portland male felt that drug and alcohol counselors were more understanding because he perceived that these counselors had been through the same experiences and could better relate to the youth and their problems with substances.

Group therapy also didn't help, say two young women who lived as teens in the same residential facility but at different times. They called the group therapy format a "dick measuring contest." Attending group counseling was a required part of their treatment at the facilities and the therapeutic objective of relating to each other simply became, for them, a "one-upping" of each other's life experiences. They stated this method is often used in group homes and treatment facilities.

Finding an appropriate counselor. The counselor's demeanor or personality and constant changing of counselors were among the many poor experiences some youth had – "It just gets to the point," states a female, "where you don't want to talk." Says one male, "I had one counselor who would just sit there and stare at me." Some felt they had to share personal feelings with a stranger, "If you can't share them with friends, family, or the people you get put around in the group home system – you don't want to share them with this adult figure who writes everything down and tells you that everything that you're doing is wrong." Many had had a series of counselors in their lives through constant moving and switching and some youth stated that when they tried to find an appropriate match it took up to 6 months between appointments. One young man stated he had an array of counselors currently, ranging from a community counselor to a psychiatrist he saw on a regular basis. (This young man, 18, spoke about an abusive step-father as a key factor in leaving home.) Youth without case workers found it especially discouraging because they didn't have the support of an adult to run interference for them in the event that they were "put off" or ignored.

Over-prescribing medication. Another barrier youth perceive in seeking mental health care is the amount of times a counselor prescribes medication. One female was resolved that all counselors did was "drug you up and forget about you – there you go – go be happy. It doesn't work." Another agreed, "There's a pill for everything nowadays." Both Bangor groups thought that drugs were over-prescribed for mental health conditions within their population, and that several times physicians are not aware that the youth are mixing drugs and alcohol or may have a prescription from another provider. One female, 19, stated:

> "They just substitute one drug for another, they're [the youth] taking a drug that, you know, people are hooked on narcotics or opiates and they're [the mental health providers] giving them a synthetic drug, that, you know, they do something stupid and

> mix it with something else – they're going to die. They're giving out synthetic drugs that will kill them if they mix it with something else…It's awful."

When asked if anyone had had a good experience with a counselor, one female stated that she did have a counselor (one out of ten counselors, she clarified) who she could relate to and who tried to connect what she was going through with the counselor's own experience. One male from Portland said that he had seen a counselor in jail because he had a problem with alcohol and drugs. He said they helped him out in jail.

Suicidal Ideation or Attempts

Ideation among friends. When the youth were asked what they would do in an event of suicide ideation or attempts among friends, answers were sometimes troubling. In two of the groups, one in Bangor and the other in Portland, respondents replied with somewhat callous indifference or insensitivity to another's expression of wanting to die by suicide. One female answers, "My sarcastic remark, is hey, make sure you do it with pills 'cause I don't want blood on my carpet." Another participant said, "Here's the gun!" From one participant in Portland, "My sister – when she talks about shit like that, I tell her to shut the fuck up and check herself into a hospital." Others indicated they would talk to their friends. When asked if they would advise a potential suicidal friend to go see a counselor or therapist – one discussion went as follows:

> Male, 18: "I've had friends who wanted to kill themselves, lots of times…. Anyways, I usually just sit down, talk with them, make them feel like - make them know that somebody cares that there's somebody there they can talk to. I'll bring them out and go for walks with them – and actually have somebody be there with them. Like a good friend should be – just there for your friends. But, if it was me who wanted to do it? I wouldn't say anything and it would just end up happening."
>
> CSB: So, you just wouldn't tell anybody. So what if somebody recognized the signs and said, hey, are you okay? *(It should be noted that the rest of the group is silent and listening during this exchange.)*
>
> Male: I'd most likely go home.

One young woman in Portland, 18, told a story about her own experience with a friend's death by suicide:

> "On February 1st, my best friend killed himself. So now, like ever since then, when people talk about it – I'm like, dude, you fuckin' know what everybody went through when he did it, so why the fuck would you put everybody through it again. I just get really pissed now. And before, I was like, well *that* sucks."

Personal suicidal ideation. I asked all the groups what they would do in the event that they themselves were having suicidal thoughts. Some answered "get high" or self-medicate. Says one male, "Drink until I pass out somewhere." Most say that they would go to friends first, "I can tell friends things that I could never tell my parents."

States another male, 18:

> "In my situation, I had nobody to talk to besides my friends, they all agreed with me – not about suicide – but my reasons for thinking the way I was…All the way from when I was 10, and that's when my old step-dad left and I realized everything that happened…because I just thought it was a normal everyday thing. So, from when I was 10 until I was – probably – I actually have suicidal thoughts to this day, but I don't act on it, I don't – I just kind of – basically go to a happy place. You know what I mean? I don't dwell on it; I just let it pass me by. I've had plenty of plans; I just remember that I promised myself that I would never cut again, that I would never become suicidal again and that I would never do anything stupid again."

Recognizing signs. I asked each group if they would know what the "signs" were if a friend didn't verbally indicate that he/she might be suicidal, but was. States one young woman in Bangor:

> "I do. I actually looked it up, cause I was feeling really depressed, and I wanted to know what I should start looking for in myself if I was going to commit suicide. Like signs, so I could stop it. And some of the main things are: giving away your most valued possessions, sleeping most of the day, not caring about your appearance, you know, not showering, doing stuff you're supposed to do, not going out hanging with friends – those are some major signs that you're probably going to commit suicide if you don't get help. [And] excessive happiness – but that could be caused by meds."

A male participant says, "Someone doesn't want to talk to anybody, sits in the corner by themselves, crying – bla, bla, bla." Another answers, "Big gashes on their arms – that's a good sign!"

When I mentioned or discussed calling a crisis hotline if youth were experiencing suicidal thoughts or had a plan for a suicide attempt, most replied that a phone call to *any* organized service would result in immediate hospitalization, and this was not an option they wanted to explore.

Maine State Agencies and Community Providers

Maine DHHS. The Maine Department of Health and Human Services (DHHS) reports there are several programs that encourage and support independent living for Maine youth who are transitioning out of foster care or DHHS custody to independence. According to the Director of the Independent Living Program, supports are in place in Maine for youth aging out of foster care and who are willing to take advantage of these services. Among those listed are extended benefits through their V9 program up until the age of 21, health insurance through MaineCare until the age of 23, and full tuition at Maine state universities and colleges (limited to 30 slots per year) through an Education Voucher program funded by the Jim Casey Foundation.

A report issued by DHHS, states that *all* the group homes, treatment foster care agencies and residential care programs in Maine that contracted with DHHS, *June 30, 2006 Program Report, Chafee Foster Care Independence Program,* had been reviewed for quality of independent living service provisions and transitional case planning. According to this report, the results were "good." (Note: this evaluation was not accompanied by protocols or methods used to determine the quality of programs other than "on-site reviews.") This report also states that "a number of treatment foster care agencies continue to provide 'congregate' and 'scattered site' apartment program services for youth in care between the ages of 17-21" (p.2). The report continues to state that these programs "now exist in the major cities of the state and in some of the more rural areas of the state as well" but doesn't say where, how many, or how many youth these apartment program services serve. There is some mention of 50 or more youth in care in Bangor who have extended their benefits through the V9 program and are living in their own apartments with state funded financial support for at least a portion of their rent and food costs. (This report does not say what the subsidies are or from which department these housing and food costs are covered.)

MaineCare is a health insurance program sponsored by the DHHS. This program is well known by youth who participated in the focus groups. Basically, MaineCare provides health insurance and benefits to all Maine residents who cannot cover the costs of independent providers, nor do they have employer covered providers. All of the youth mentioned that they were covered by MaineCare with the exception of two participants (one claimed he didn't qualify because of income; the other had turned 21 and had not re-submitted paperwork). MaineCare provides financial support for health care appointments, limited prescription medication, and limited rides to health care appointments. Yet, only those with diagnosed disabilities qualify for MaineCare coverage after the age of 21 years. Though this program also has a "non-categorical waiver" that covers 11,000 Mainers per year, there is a waiting list of approximately 2,000. Every six months the list is reviewed and those on the waiting list replace those who have dropped out of the program if they are still eligible. This was the only state-run program which all youth were knowledgeable about or mentioned as a service that they utilize on a regular basis.

Also supported by the Maine Department of Human Services is the Maine Community Mentoring program, a project of the Bureau of Child and Family Services and the Youth Development Unit of the Muskie School of Public Service at the University of Southern Maine. This program works specifically in Cumberland and York counties to match youth, 11-21, in Maine's foster care system with a mentor to provide opportunities for youth in foster care to achieve a sense of community. However, further investigation revealed that the Community Mentoring Program has slowed down significantly, and is currently low or non-operational at this writing.

Muskie School of Public Service. The Muskie School of Public Service, along with DHHS also provides services to youth aging out of foster care. Opportunity Passport is a program funded by the Jim Casey Foundation. This program's objective is to help youth save money through a bank sponsored savings account for such things as adult education courses, down-payment or deposits for housing and to help them gain access to training and vocational opportunities. Currently, this program serves 225 youth ages 21-24 across the state with enrollment limited to 75 youth per year; maximum enrollment has been reached at this

writing. Also undergoing a transition, according to Esther Attean, Site Coordinator for Maine Youth Opportunities Initiative, Opportunity Passport will be administered through Jobs for Maine Grads (JMG). JMG has plans "to incorporate the financial literacy into their curriculum through their specialists housed within schools, they also plan to have master specialists work with out of school youth" (Esther Attean, email, 5/18/07).

Outreach Providers

Shelters. Two of the programs that have high contact with disconnected youth were the Streetlight Outreach Program in Bangor and Preble Street in Portland. These outreach programs were similar in that they provided food, shelter, clothing, medical and counseling services to the youth who requested help. The Streetlight Outreach Program, as a part of the Shaw House, also houses an 8-bed residential shelter for teens to age 21, and a 16-bed temporary shelter for 17 to 24 year olds. This outreach program, as indicated by Chris Betts, Outreach Program Manager sees approximately 300-400 older adolescents per year. They are mostly from Aroostook, Piscataquis, Penobscot and Lincoln counties.

The population of this facility ranged from the transient youth, who may come for services once or twice and then "disappear," to the "chronically homeless" who remain in the area. The Program Outreach Manager at the Bangor site describes this program as a "conduit to services." He states that when the youth come to them, the staff links them to appropriate adult services, such as MaineCare for medical needs, to counselors for mental health and drug counseling. They also provide transportation to medical appointments, including mental health care, and to look for jobs in the local area.

One program offered by Streetlight in Bangor regularly meets at 7:00-9:00 p.m. on Monday nights. No one under 18 years old is allowed to be in this group. When the doors open, two to three staff are ready with sandwiches or pizza, juice or water, vegetables and snacks and there is no restriction on the amount of food a youth can eat. The program meets in a small room with a pool table, couches and a TV. The program manager, on the evening of the scheduled focus group, played a guitar, walked around, and talked to the youth, while another case manager, a licensed social worker, was at a desk with a computer and spoke to the participants as they came into the room. The atmosphere was one of cordiality and fun. All the youth seemed comfortable, not only with the staff, but also with each other. They sat on chairs or played pool; they wandered around and mingled with each other. Overall, there was a definite feeling that this group felt a sense of belonging to this place.

The Portland Preble Street Teen Center opens their doors at 10:00 a.m. daily. This is a larger facility with conference rooms, a lobby with several couches and an adult education center that helps youth obtain their General Educational Certificate (GED) as well as helps them navigate the education process should they want to go on to post-secondary institutions. On-site were mental health substance abuse counselors, a nurse practitioner, and a doctor's office. Adjacent to the Drop-in Center was the shelter where many of the youth who participated in the focus group stayed at night. A Tuesday morning was the best time to access this population. The youth were offered apples in the morning, and are offered lunch and dinner on a daily basis. The outreach director at this program also believes that services are getting better for this population. She mentions several programs in the Portland area such as Youth

Alternatives, Learn to Earn, Jobs for Maine Grads, and a Rental Assistance Coupon Program that provides free housing up to 2 years for 18-25 year olds.

Another outreach provider, Breakwater Teen Center in Rockland also provides shelter to teens up to the age of 18. Lynn Jackson, manager of this program explained that when a youth turns 18 (on their birthday) they are asked to leave the shelter. This program also has a drop-in program for homeless youth to the age of 21, and serves mostly Waldo, Lincoln and Knox counties. Service providers at the shelter state that youth between the ages of 18-21 in their area are in a sort of "limbo;" they often end up in jail, may spend their evenings in an ATM booth, or more typically, "couch surf" if they do not find shelter at one of the larger sites in Penobscot or Cumberland county. Having little to no resources for this population is the biggest challenge in this region.

Other Community Providers

Churches and food banks. Community providers that may not be served or funded by state or federal agencies are also involved in providing disconnected youth with food, clothing and shelter. Among those providers mentioned by project coordinators were numerous community churches that run food pantries, volunteer soup kitchens, a privately run Hospitality House in Rockport for those aging out of the Breakwater Teen shelter, and the Salvation Army. Others, like the Maine Youth Transition Collaborative[8], are utilizing community connections to provide one-on-one mentors that will help youth gain life skills, or to donate items for first apartments or other services, such as a driver's education course.

Substance abuse treatment and mental health centers. Michael Morse, a substance abuse counselor of Choice Skyward, a full-service substance abuse clinic, in Rockland, Maine, and Betty Carolin, from the Charlotte White Center in Dover-Foxcroft, were among the service providers in the target areas that discussed their programs, challenges and trends they perceive in the 18-24 year-old population they serve. Morse explained that he has been serving youth in various capacities for several years in the mid-coast region. Most of the youth referred to Choice Skyward are treated on an out-patient basis. Overall, Morse believes, he is seeing more opiate addiction in the mid-coast region. He also states that there are no agencies that provide addiction services other than Mid-Coast Mental Health and PenBay Medical Center. He believes that some of the biggest challenges are financial. He explains that they often provide care for self-pay consumers, which he says, amounts to basically free services because either the youth cannot pay, or MaineCare reimburses at such a low rate that it is frustrating for providers who are trying to maintain services. The challenges he sees for youth in the area are relatively poor prospects for obtaining a job, lack of accessible transportation and that this region is "not a resource rich environment."

The Charlotte White Center in Piscataquis county, serves clients diagnosed with autism, asbergers or Obsessive Compulsive Disorder (OCD), among others. The adult services at this facility range from medical management, up to the age of 26, to a residential and vocational training program for 18-24 year olds with a mental health diagnosis. This program offers education that caters to individual interest and abilities with opportunities for long-term employment after a couple of years. Most of the clients come from the Bangor area and have been referred by the state; some have state guardians. One challenge for the Center is

receiving more referrals to the residential program for youth who are 18-24 and who are higher functioning than the program typically accepts.

Community non-profits. The Maine Youth Transition Collaborative (MYTC) has offices in Portland, Bangor, Caribou and Augusta. This initiative started in 2004 through funding by Jim Casey, FourSquare Foundation, and in collaboration with The Muskie School for Public Service and the Maine Office of Child and Family Services. This group networks with others to form a foundation of care for disconnected youth aging out of foster care seeking services or help. The objective of this network is to "improve the successful transition of youth in foster care to adulthood."[9] Expectations of this 20-member collaborative are to expand options through community volunteers and help youth in foster care connect to resources that will help them with housing, employment, education, health and permanency (from the MYTC Sustainability Plan, p. 14) While they have connected with many youth, including donations of furniture and advising youth of opportunities, they run into roadblocks in finding the youth who are disconnected from the system. They also rely somewhat on word-of-mouth to advise youth of the assistance they will provide.

Challenges for Service Providers in Working with this Population

Several service providers offered some of the challenges they typically encounter in working with disconnected youth. Among those are:

- Difficulty setting long-term goals and short-term goals; i.e. youth often don't show up for appointments even when they need or ask for assistance.
- Teen pregnancy.
- Substance abuse.
- Youth does not realize the importance of education.
- MaineCare reimbursement rate for service providers is too low.
- Youth have low to no motivation to make situation better.

The challenges and barriers service providers believe this population face (besides lack of housing) are:

- Lack of continuity in their lives.
- Little to community integration or sense of belonging.
- Transportation (Knox county providers).
- Many come from poverty and/or dysfunctional family situations - being dysfunctional is "normal."
- Poor social skills.
- No education beyond high school.
- High school dropouts (no diploma or GED).
- Little to no job opportunities (Knox county providers).

Many of these providers have seen changes in trends, attitudes and demographics in this population. Among those are:

- More extremes – especially in the mental health care field

- Adolescent attitude of entitlement to help without accountability
- Younger youth needing services
- More referrals
- Difficulty convincing them to stay at the shelters and not on the streets
- More opiate addiction in mid-coast Maine

Research Limitations

Sample

Because of the small sample size and access to only two sites, this research cannot claim to make broad generalizations about the disconnected population in Maine. Also, the sample population is very transient, so access to youth who are from a specific region or county in Maine is difficult. Many originate from areas where they have aged-out of residential care in their community, some at 18, so they move to the larger service areas like Bangor, Augusta, and Portland. Homelessness and joblessness means that living situations are tentative, at best, and highly unstable.

Focus Group Method

Trust is difficult for this group of young adults and a focus group atmosphere may inhibit their answers or may be intimidating for some participants so that they will not contribute to the discussion, and especially if they are unwilling to share sensitive issues with an audience. For some participants, a focus group might cause a "performance" effect, whereby a participant might say something to get a laugh or the approval of his/her peers, but not truly believe what he/she says. Efforts were made in all cases to keep the conversation at a level where no one person dominated and any tangential or extraneous information was brief. Because the groups were audio-taped, I could go back and listen to determine what comments might be considered "performing" in front of peers and what was authentic information. Comments that seemed out of context or seemed to be made to "shock" or get a laugh were carefully considered for their merit, and noted only if there were similar comments in other groups. This sort of selection of comments on which to report may limit the data in that researcher's perspective is included as part of the findings; however, my experience in working with at-risk and high risk adolescents could serve to buffer a misinterpretation of a participants response and care was taken to ensure all responses were considered.

Recommendations and Strategies for Supporting Disconnected Youth

> *"Homeless and runaway youth require a continuum of support around employment, education, health care, drug and alcohol treatment, mental health treatment, and housing."*
>
> (Van Leeuwen, *Reaching the Hard to Reach*, p. 456)

Literature

Much of the literature on disconnected youth offers strategies for communities and service providers to help youth transition into secure and sustainable independent living. Having adequate and multiple supports in place arguably decreases incidents and factors that lead to suicidal ideation and/or attempts. Below is a list of some activities that can be implemented by individuals, non-profit agencies, community agencies, and at the community or state level:[10]

- Provide mentoring adults in the community
- Vocational training
- Life skills training
- Financial literacy training
- Educational assistance
- Supervised practice living
- "Aftercare" by child welfare services
- Job placement and retention
- Substance abuse/preventative health activities
- Provide personal/emotional support
- Provide housing
- Call on foundations/other private organizations to become more involved and include financial support for transitioning youth to age 25
- More research, development, innovative projects
- Pre-approval to register for college courses
- Expedited access to job-training/adult education
- Provide driver education
- GED preparation
- Reimbursement for high school graduation expenses
- Financial assistance with a cap on allotment
- Match federal funding for state programs
- Increase coordination efforts between foster care system and other systems/programs

Maine Providers

Maine care providers were asked what they would like to see implemented that would help this population be less vulnerable to mental health issues. Among their responses were:

- More re-integration programs for transitioning youth
- A tiered housing program in a supervised environment

- More community integration programs
- Welfare reform - use a strengths-based (skills) system not a reliance-based (need) welfare system
- More training in independent living and other life skills; i.e. driver ed, job searches, financial literacy
- Eliminate hoops in school systems – give youth at-risk more opportunities to graduate
- More providers to come to the youth rather than relying on youth to go to providers
- Improve the system – too hard to access services
- More prevention services
- Holistic approach to care - greater collaboration between service systems with funding to coordinate health care and mental health services
- Universal health care system

Youth Recommendations

The youth in the focus groups were also asked to recommend what they would like to see implemented to make it easier to set and meet goals for their future. Among those recommendations are:

- Housing – Having to get an apartment without the first lump sum payment. The security, last and first months rent can sometimes total $1500-$2000 and is difficult, if not impossible for them to save. Also, there are long waiting lists for subsidized housing.
- More independent living training.
- Workshops on how to find an apartment and how to find a job.
- Safety – "Shelters need to realize that a lot of girls on the streets have had problems with rape, and abuse and abusive boyfriends and they need to make the shelters safer."
- Transportation to appointments (this was from the Portland focus group). Need transportation to fill out applications and go to job interviews.
- Counselors should try to relate to the youth on their level.

Discussion

> *"There are currently twenty-four million twelve- to seventeen-year-olds in the United States…[I]t is likely that at least a million and a half of these youth, from 5 to 7 percent, will reach age twenty-five without having successfully transitioned to independent adulthood."*[11]
>
> (Wald, from *On Your Own Without a Net,* 2005, unpaged)

This quote is taken from a recent publication of the John D. and Catherine T. MacArthur Foundation Research Network on Transitions to Adulthood. A national look at youth aged 18-24 is instrumental in understanding the challenges and barriers disconnected youth face as they transition to adulthood and after having grown up in state and federal systems of care. Several studies, such as, *On Your Own Without a Net,* explore challenges for service care providers, for youth aging out of foster care and child welfare benefits and for those who are transitioning into adulthood from incarceration. Other programs, such as the Urban Peak[12] housing program in Denver offer recommendations for policy and program-

matic changes on a state and national level that seemingly, and if implemented, makes the transition from homelessness smoother for this high-risk population.

According to the MYSPP community service coordinators and some youth who volunteered to interview, some barriers to adequate and appropriate mental health care is transportation, knowledge about how to access mental health care and limitations on services and medications that MaineCare will provide. Any limitations of services or medication for mental health care is significant because youth aging out of foster care, or homeless youth, often have mental health issues that may be compounded by other emotional trauma.

The participants in the Maine focus groups could safely be called "system kids." Many grew up in state custody and experienced numerous amounts of counselors, case workers, foster homes and group homes. As children, their transient lifestyle wasn't by choice, but rather by removal from homes and group homes at the request of the foster parents, DHHS or for behavior. Schooling was interrupted several times as was any feeling of permanence or belonging to any one community. All are familiar with "couch surfing" or "couch hopping" whereby they live with anyone who will give them a place to stay for the night. They have experienced shelters and food cupboards. They are familiar with the "streets" - homelessness, abuse, both familial and within their social circle (one female mentions "boyfriend rape") and they know how to defend themselves – many females carry knives. Several indicated that they had been in youth detention facilities in the past. For most of their lives, these young adults have been outside any type of long-lasting family situations and have not experienced long-term relationships with adults or peers who are not required by law or profession to be their care providers. When they speak retroactively about their care providers as children, they use the word "staff," not family. States one young woman, 21, who aged out of foster care, "Being in group homes – nobody gives a shit about you. You move in with all these random kids that you have to be friends with because you're in the same situation."

This systemic upbringing has significantly affected how this group of young adults view the world, and now, adult-aged, how they view professional health care providers and especially counselors or therapists. Trust or feelings that they are getting the best care possible, has been disappointing for these individuals. Even though several of these youth have severe emotional and sometimes physical disabilities, MaineCare is limited in what they will provide. There is a list for prescription drugs that is available to them, and (as one female mentioned) physician recommended surgery is often *not* covered. Self-medication was discussed among the participants as options to relieving pain (both emotional and physical) and this could range from alcohol abuse to prescription "street" drugs. Three participants admitted to "cutting" or previously cutting to relieve emotional pain.

Many who are not or were not in state custody, either they had run away or had been "kicked-out" by family as teens or who chose at 18-19 years to opt out of state care, are truly disconnected. Without access to the internet, case managers, mentors, or service providers who can direct them to services, they are nearly invisible. There is a seemingly endless chain of providers, some with little awareness of the services others are providing. As a mentor to a young woman who chose to leave the system as an 18-year-old and who has now been accepted to college, I've witnessed her trying to secure counseling, educational benefits and health care benefits with long waiting periods between appointments and even return phone

calls. The forms and with a long list of conditions to receive MaineCare, the Free Application for Federal Student Aid (FAFSA) and the college application are lengthy and sometimes complex. As a high school dropout with a GED, taking the often frustrating steps forward that many teens with parents take for granted, would not have happened without a mentor to guide and support her process.

Many of these youth cannot envision goals or opportunities to improve their living conditions because they don't know the questions to ask, nor do they have the resources to put these goals into motion. During the course of the discussion with program directors and state agencies about how disconnected youth find out about programs available to them, the answer was that referrals for eligibility were typically by case workers, service providers and often these providers relied on "word-of-mouth" from the youth themselves.

Another observation is that these youth, and most especially youth who have been in state custody as children, are perceived by many providers to have adequate health care, support and services. It appears from the conversations from privately funded community outreach providers that programs such as Opportunity Passport and the Maine Youth Transition Collaborative are established and serving youth. However, none of the youth interviewed described that they access these services or that they even know about some of the opportunities available to them.

Independent transitional living programs are discussed by DHHS, in their 2006 report, as working well; however, many of the youth interviewed who were in state custody did not believe that they received any information or training about how to secure a job, secure an apartment, balance a checkbook or manage a household budget. One young man said that his "transitional living program" consisted of cooking one group meal per week and "shopping." He says, "They didn't even have any cookbooks, how am I supposed to cook without a cookbook?" Another young woman, 21, stated, "I remember being 13 in a group home and they were trying to teach me to balance a checkbook – but I was 13. I didn't have any money and I've forgotten it now." One participant, 23, explained that he was currently living on his own and believed that he had had excellent independent living skills training at the Charlotte White Center in Dover. It should be noted that the Charlotte White Center is exclusively for those with diagnosed and often disabling mental health conditions.

In conclusion, even with extensive networking, programs and services there is still a need for 1) better communication among care providers, state agency personnel and outreach program directors as to what services are available to youth – several service providers rely on youth "word-of-mouth" for programs that might help them secure a job, an apartment or transportation.; and 2) services that address homelessness and joblessness among runaways or "kick outs" who have never been in state custody, as programs to help them secure a more hopeful future, such as education vouchers or Opportunity Passport are not available to this population.

Further Research

Additional research on the numbers of 18-24 year olds living in shelters or disconnected from any services should be done. Currently, Maine reports that 14% of 18-24 year-

olds are either homeless, jobless or have no further education beyond a high school diploma. While many services providers and community support groups recognize that youth who are in or who have been in state custody need help transitioning from state care, it appears only a minimal amount of youth to which their services apply are receiving help. Youth who are ineligible for state or federal services, i.e., homeless youth who are runaways or have been "kicked out" or youth exiting from detention centers and incarceration who have never been in state custody do not have access to independent living programs or support beyond what they receive as a shelter resident. Many of these youth also suffer deep emotional scars from abuse and neglect and have been exposed to "street life" at a variety of levels. Several of them have families of their own. This population is truly disconnected and may be more susceptible to suicidal ideation because there is seemingly "no way out." As one young woman in the focus group stated, she had to be arrested to access some services.

One study in Denver[13] used a point-in-time survey administered to youth on the streets to identify and understand the needs of their specific population. It might be useful to consider such a survey to identify which populations of 18-24 year olds are more vulnerable to suicidal ideation or attempt in Maine, and how many and which service providers they typically access. This information could lead to better understanding this high risk population and provide programs that include suicide prevention and intervention training, as well as reduce suicidal attempt among this population.

Endnotes

[1]SOURCE: WISQARS Leading Causes of Death Report, www.webappa.cdc.gov., access date: 1/8/2007.
[2]SOURCE: www.aecf.org/kidscount
[3]Disconnected youth will be defined as youth who are 18-24 years of age, are out of work, out of school, and may have aged-out of child welfare and state benefits, including the foster care system. Typically, these young adults, if they have not dropped out of high school, will have no degree beyond a high school diploma or a GED credential.
[4]Tondo, L., Albert, M.J., & Baldessarini, R.J. (April 2006). *Suicide rates in relation to health care access in the United States: An ecological study.* Journal of Clinical Psychiatry, 67(4) 517-523.
[5]Courtney, M.E. & Heuring, D.H (2004). In Shirk, M. and Stangler, G. (Eds.) *On Their Own: What Happens to Kids When They Age Out of the Foster Care System*. Jim Casey Youth Opportunites Initiative. Boulder, CO: Westview Press.
[6]Source: www.mekids.org.
[7]As an interviewer, I didn't want my participants to become uncomfortable and not be able to answer the hard questions. Therefore, before I jumped into the questions about suicide ideation and their experiences, I started the focus groups by asking about access to health care. The responses are organized, in general, in the same order in which the respondents were asked the questions.
[8]Nancy McKechnie, FourSquareFoundation in collaboration with Muskie School for Public Service
[9]Maine Youth Transition Collaborative Sustainability Plan, April 2007.
[10]*The Finance Project,* Rachel H. Sherman, October 2004, Serving Youth Aging Out of Foster Care.
[11]Wald (2005). In Osgood, D.W., Foster, E.M., Flanagan, C. & Ruth, G.R., (Eds.) On Your Own Without a Net. (unpaged) Chicago: The University of Chicago Press.
[12]Van Leeuwen, J. (2004). *Reaching the hard to reach: Innovative housing for homeless youth through strategic partnerships.* Child Welfare League of America.
[13] Ibid.

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